Washington State Health Care Authority
Public Employees Benefits Board

A-OE

Clear Form

2013 Retiree Coverage Election Form (Open Enrollment)

- **List eligible family members you wish to cover or remove from coverage. This form replaces all *Retiree Coverage Election Forms* previously submitted.**
- **If deferring PEBB retiree coverage, complete sections 1 and 7.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- If adding a dependent with a disability age 26 or older, or an extended dependent, attach appropriate certification form(s). Forms are available at **www.pebb.hca.wa.gov** or by calling 1-800-200-1004.
- If you are a non-Medicare retiree and adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled. A list of documents we will accept to show proof of eligibility is in the *Retiree Enrollment Guide* and available at **www.pebb.hca.wa.gov** under *Dependent Verification*.
- If you are a surviving spouse, state-registered domestic partner, or dependent, provide the social security number (SSN) of the deceased retiree or employee in the "Retiree or employee information only" section below. Provide **your** SSN in "Section 1: Subscriber Information."

Retiree or employee information only	Retiree or employee name
	Retiree or employee social security number
Additions or changes *Check all that apply.*	**What change are you requesting?** ❑ Name ❑ Address ❑ Medical plan ❑ Dental plan
	Change in family status: ❑ Removing a spouse or dependent ❑ Adding a spouse or state-registered domestic partner *If adding a registered domestic partner, please attach a* Declaration of Tax Status *form.* ❑ Adding a family member 1 (from Section 3) ❑ Adding a family member 2 (from Section 3) *If adding a child of your domestic partner, please attach a* Declaration of Tax Status *form.*

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F
Street address / Apt./unit number		City	State	ZIP Code
Mailing address (if different than above) / Apt./unit number		City	State	ZIP Code
County of residence	Date of birth (mm/dd/yyyy)	Daytime phone number (including area code) ( )	Home phone number (including area code) ( )	

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Subscriber's last name	First name	Middle initial	Social security number

Section 1: Subscriber Information *(continued from page 1)*

Election Check the boxes that apply to you.

❑ **Enroll:** ❑ Medical only ❑ Medical and dental

❑ **Cancel coverage.** I understand that I am forfeiting all further rights to enroll in the PEBB Program unless I regain eligibility. Cancel date_____

❑ **Defer my coverage.** Identify below your medical coverage that allows you to defer PEBB retiree coverage. **See also Section 7. Except as stated below, this defers coverage for all family members.**
Deferral date_____

❑ **Enroll (after deferring coverage).** Identify below the medical coverage you have been enrolled in since deferring enrollment in PEBB retiree coverage. **You must provide proof of continuous coverage since your date of deferral (begin and end dates).**
Date other coverage ended_____

If deferring or enrolling, check the box below that applies to you:

❑ Enrolled in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.

❑ Enrolled under another comprehensive, employer-sponsored medical plan as an employee or employee's dependent, including insurance coverage continued under COBRA.

❑ Enrolled in Medicare Part A and Part B, and a Medicaid program that provides creditable coverage. (You may continue to cover eligible family members who are not eligible for creditable coverage under Medicaid in a PEBB plan.)

❑ Enrolled in medical coverage as a retiree or dependent in a federal retirement plan, such as TRICARE.

Enrolled in Part(s) A and/or B of Medicare? If yes, attach a copy of your Medicare card to this election form if we don't already have a copy.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, may only enroll in Premera Blue Cross Medicare Supplement Plan F. ❑ Yes ❑ No If yes, effective date_____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date_____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date_____

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2013 Retiree Coverage Election Form (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social security number

Section 2: Spouse or State-Registered Domestic Partner Information

List an eligible spouse or state-registered domestic partner you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If you are a non-Medicare retiree adding a spouse or partner, you must provide proof of eligibility within PEBB's enrollment timelines or the spouse/partner will not be enrolled.***

Relationship to subscriber (If adding a state-registered domestic partner, please attach a completed *Declaration of Tax Status* form.)

❑ Spouse: date of marriage_____ ❑ Domestic partner: date registered_____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy)

PEBB coverage for spouse/partner
❑ Cover ❑ Remove Effective date_____ Reason_____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, may only enroll in Premera Blue Cross Medicare Supplement Plan F. ❑ Yes ❑ No If yes, effective date_____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date_____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date_____

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

List eligible family members you wish to cover or remove from coverage. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time. ***If you are a non-Medicare retiree adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or they will not be enrolled.*** *If adding a child or your state-registered domestic partner, also attach a* Declaration of Tax Status *form. Attach certification forms(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent.*

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Relationship to subscriber	Last name	First name	Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	Disabled? *(Check only if age 26 or older)* ❑ Yes ❑ No

Street address	Apt./unit number	City	State	ZIP Code

PEBB coverage for family member
❑ Cover ❑ Remove Effective Date_____ Reason_____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, may only enroll in Premera Blue Cross Medicare Supplement Plan F. ❑ Yes ❑ No If yes, effective date_____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date_____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date_____

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2013 Retiree Coverage Election Form (Open Enrollment)

Subscriber's last name	First name	Middle initial	Social security number

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

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2 **Relationship to subscriber** | Last name | First name | Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	Disabled? *(Check only if age 26 or older)* ❑ Yes ❑ No

Street address / Apt./unit number	City	State	ZIP Code

PEBB coverage for family member
❑ Cover ❑ Remove Effective Date_____ Reason_____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, may only enroll in Premera Blue Cross Medicare Supplement Plan F. ❑ Yes ❑ No If yes, effective date_____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date_____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date_____

3 **Relationship to subscriber** | Last name | First name | Middle initial

Social security number	Date of birth (mm/dd/yyyy)	Sex ❑ M ❑ F	Disabled? *(Check only if age 26 or older)* ❑ Yes ❑ No

Street address / Apt./unit number	City	State	ZIP Code

PEBB coverage for family member
❑ Cover ❑ Remove Effective Date_____ Reason_____

Enrolled in Part(s) A and/or B of Medicare?
If yes, attach a copy of your Medicare card to this election form.

Part A (hospital) ❑ Yes ❑ No If yes, effective date_____

Part B (medical) ❑ Yes ❑ No If yes, effective date_____

Enrolled in Part D (prescription-drug coverage) of Medicare? If yes, may only enroll in Premera Blue Cross Medicare Supplement Plan F. ❑ Yes ❑ No If yes, effective date_____

Enrolled in Medicaid with Medicare Part D? ❑ Yes ❑ No If yes, effective date_____

Receiving Social Security Disability? ❑ Yes ❑ No If yes, effective date_____

(continued)

Subscriber's last name	First name	Middle initial	Social security number

Section 4: Medical Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative[1]
- ❑ Group Health Classic
- ❑ Group Health Medicare Plan[2]
- ❑ Group Health Value

Group Health Options Inc.
- ❑ Group Health Consumer-Directed Health Plan[3]

Kaiser Foundation Health Plan of the Northwest
- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan[3]
- ❑ Kaiser Permanente Senior Advantage[1]

❑ **Medicare Supplement Plan F, administered by Premera Blue Cross[4]**

Uniform Medical Plan, administered by Regence BlueShield
- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan[3]

[1] These plans offer Medicare Advantage plans to Medicare enrollees in certain counties. Complete and attach the *Medicare Advantage Plan Election Form* (form C) if you live in a county where Medicare Advantage is available.

[2] If you cover family members not enrolled in Medicare, also select Group Health Classic or Group Health Value for your non-Medicare family members.

[3] These plans are available only to retirees not enrolled in Medicare. If you cover a dependent enrolled in Medicare, you must cancel your dependent's PEBB coverage to enroll in this plan. Your dependent will not be eligible for COBRA or other continuation of coverage options.

[4] Also complete and return form B to enroll in Medicare Supplement Plan F. PEBB does not offer the high-deductible Plan F.

Please sign and date this form on page 7.

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Subscriber's last name	First name	Middle initial	Social security number

Section 5: Dental Plan Selection *Check only one.* ***You must enroll in medical coverage to enroll in dental.***

If you select retiree dental coverage for yourself, you must keep retiree dental coverage for at least two years. However, you may change retiree dental plans within those two years. Contact the plans for benefits information; their contact information is located at the end of this form.

Preferred Provider Organization

❑ Uniform Dental Plan, administered by Washington Dental Service (Group #3000)
(may receive services from any provider)

Managed-Care Plans

❑ DeltaCare, administered by Washington Dental Service (Group #3100)

Dentist name or clinic code_____
(must receive services from a DeltaCare provider)

❑ Willamette Dental of Washington, Inc.

Clinic location_____
(must receive services from a Willamette Dental Group provider)

❑ **Cancel Dental**

I understand that I may only cancel this coverage if I have maintained enrollment in a PEBB retiree dental plan for at least two years or if I am deferring or disenrolling from my PEBB account as this is allowed under PEBB rules (Section 7). If I cancel dental for myself, dental is automatically cancelled for my enrolled dependents.

Section 6: Authorization for Premium Payment

I authorize the Department of Retirement Systems to deduct from my retirement allowance the amount I am required to pay for this coverage.

❑ **Yes,** deduct from my pension.

❑ Continue to deduct from my electronic debit service

❑ **No,** I will send my payment monthly.

If enrolling after deferring coverage and not electing to have your premiums deducted from your pension, you must send your first monthly payment before we can enroll you. Please enclose your check **payable to the Washington State Treasurer** and send with this form to Washington State Health Care Authority, P.O. Box 42695, Olympia, WA 98504-2695.

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Subscriber's last name	First name	Middle initial	Social security number

Section 7: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we are eligible. To the extent permitted by law, PEBB may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office or another state.

If I send payment, this does not mean I will be automatically enrolled in PEBB insurance coverage. The PEBB Program will verify eligibility for me and my family members. If I am not enrolled in Medicare and apply to add a dependent to my PEBB coverage, I must provide copies of documents that verify the dependent's eligibility within PEBB's enrollment timelines or PEBB will not enroll him or her. If we do not qualify, I will receive a refund of premium payments.

I understand that if I enroll in PEBB retiree dental, I must remain enrolled in retiree dental for at least two years.

I understand if I or any enrolled family member is entitled to Medicare Part A and Part B, we must enroll and remain enrolled in Medicare Part A and Part B.

If I choose to defer medical/dental, I understand I can reenroll no later than **60 days** after losing other health coverage or during the annual open enrollment period with proof of continuous enrollment. If I defer enrollment for myself, I cannot enroll my eligible family members except as stated below.

I can defer enrollment in a PEBB health plan for:

- Enrollment in a PEBB or Washington State K-12 school district-sponsored medical plan as a dependent.
- Comprehensive, employer-sponsored medical coverage that is not retiree coverage.
- Medicare Part A and Part B, and a Medicaid program that provides creditable coverage. (You may continue to cover your family members in PEBB coverage in most cases.)
- Federal retiree coverage (may only re-enroll in PEBB health plan[s] once).

If I am enrolling in a consumer-directed health plan with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that the PEBB Program will direct a portion of my monthly premium to an HSA based on the information I have provided, and that there are limits to these contributions and my HSA contributions, if any, under federal tax law.

If I die, my eligible surviving family members must complete an enrollment form to enroll in or defer PEBB retiree insurance coverage no later than **60 days** after my death.

This form replaces all *Retiree Coverage Election Forms* previously submitted to PEBB. If I previously elected retiree term life insurance it will remain in effect until I cancel it.

If you are a retiree receiving benefits from the Department of Retirement Systems (DRS), the PEBB Program may share your information with the DRS to better serve you.

HCA's Privacy Notice: We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-725-0440 or go to **www.hca.wa.gov**.

Subscriber's signature_____ **Date** _____

Be sure to sign and date this form. Mail completed form and documentation to:
Washington State Health Care Authority, PEBB Program, P.O. Box 42684, Olympia, WA 98504-2684
or fax to: 360-725-0771

Questions?

Visit our website at **www.pebb.hca.wa.gov** or call the PEBB Program at 1-800-200-1004.

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2013 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Group Health Options Inc., 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233
1-888-901-4636 or TTY 1-800-833-6388

Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099
1-800-813-2000 or TTY 1-800-735-2900

Premera Blue Cross, P.O. Box 327, Seattle, WA 98111-0327
1-800-817-3049 or TTY 1-800-842-5357

Uniform Medical Plan, administered by Regence BlueShield, P.O. Box 2998, Tacoma, WA 98401-2998
1-888-849-3681 or TTY 711

2013 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-650-1583

Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157
1-800-537-3406

Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611
1-855-433-6825